

FMLA LEAVE REQUEST FORM

To be completed by employee and/or supervisor, and submitted to the unit human resource contact

Employee _____ PCN _____ Class Title _____

Department/Unit/Section _____ Date of Hire _____

Supervisor _____ Date notified by employee _____

REASON FOR LEAVE

Adoption of child _____ Placement of foster child _____ Birth of child _____

Serious health condition of employee _____

Serious health condition of employees spouse, child or parent _____

Provide description/details as appropriate: _____

TYPE OF LEAVE REQUESTED: ___Continuous ___Intermittent ___Reduced Hours

If FMLA is approved, do you wish to use available sick leave, vacation time and/or compensatory time while on FMLA? Yes No

If so, which do you wish to use? Sick [] Vacation [] Compensatory []

Explanation of length and type of leave requested: _____

Date leave to start: _____ Date of anticipated return to work: _____

Signature of Employee or Representative *Date* *Supervisor's Signature* *Date*

Received by: _____
Signature of HR contact *Date*

**Family and Medical Leave Act of 1993
MEMORANDUM OF UNDERSTANDING**

[Date]

TO: _____
(Employee's Name)

FROM: _____
(Name of Human Resource Contact, Supervisor or Other Authorized
Official as appropriate)

SUBJECT: Family/Medical Leave

On _____ (insert date)

you notified us of your desire to take family/medical leave due to:

we became aware that the leave you are currently taking may qualify as family/medical leave since it is apparently being taken due to:

- the birth of a child, or the placement of a child for adoption or foster care; or
- a serious health condition that you need care for; or
- a serious health condition affecting your: spouse, child,
- parent, for which you are needed to provide care; and you may request that this period of leave be designated as family/medical leave.

We understand that this leave began or will need to begin on _____ and that you expect to return to work on or about _____.

The following information will explain your rights and obligations under the federal Family and Medical Leave Act (FMLA). This explanation makes no attempt to cover all aspects of FMLA that may apply to your situation. Please contact your agency Human Resources Office or refer to the FMLA regulations for answers to any questions that you have, now or at any time during FMLA leave.

Except as explained below, you have a right under the FMLA for up to twelve (12) workweeks (480 hours for full-time employees) of unpaid leave if:

- a) You were maintained on the payroll as an employee for the State for some part of each of fifty-two (52) weeks; and
- b) You worked at least one thousand two hundred fifty (1,250) hours in the twelve (12) months preceding the effective date of the leave; and
- c) You provided such advance notice as is practical in your particular situation.

1. Your Eligibility:

Based on initial review:

You are [] eligible [] not eligible for leave under the FMLA. (explain).

At this time, you have ____ [insert number] hours of FMLA eligibility.

The twelve (12) months during which FMLA leave may be taken is calculated on a rolling basis, measured backward from the date you use any FMLA leave.

2. Leave Designation:

The Department will determine whether the leave you have requested qualifies as FMLA leave. Any period designated as FMLA leave will be counted against your entitlement of twelve (12) weeks of leave. In this case, your requested leave [] will [] will not be counted against your annual FMLA leave entitlement.

You may choose to use accrued paid sick leave, vacation leave and/or compensatory time for your FMLA leave period, whenever use of the leave is allowable under other applicable state and department leave policies and rules. If accrued paid sick leave, vacation leave, and/or compensatory time are used, those balances will be reduced accordingly. Also if accrued paid sick leave and/or vacation leave are taken, credited state service is accrued. If unpaid leave and/or compensatory time are taken for FMLA, no credited state service is accrued.

Based on the information we currently have available, we estimate that your requested FMLA leave will be calculated as follows [insert numbers]:

_____ **Total hours of FMLA leave consisting of:**

_____ **hours of paid sick leave**

_____ **hours of paid vacation leave**

_____ **hours of paid compensatory time**

_____ **hours of unpaid FMLA leave**

3. Medical Certification:

You [] will [] will not be required to furnish a medical certification of the need for leave for a serious health condition. If required, you must return the enclosed certification within fifteen (15) calendar days, unless more time is requested and approved. Be sure the information is complete and signed by the health care provider of your choice. If you fail to return the medical certification, you may be denied the leave.

You [] will [] will not be required to furnish recertification every 30 days relating to a serious health condition (explain below, if necessary).

4. Benefits and Premium Payments:

If you take leave without pay for the FMLA leave period, you must self-pay your portion of the premiums for your medical, dental and supplemental life insurance, if applicable. The Department's share of these premium payments will be made automatically as long as you make the required self-payments. Contact your unit's HR contact for payment requirements and procedures.

If you do not make the required payments, or if you do not make timely payments, your insurance may be canceled. If coverage is canceled during the period of FMLA leave, it will be reinstated immediately upon your return to work. Reinstatement of medical insurance will be made without any qualifying period or physical examination.

For more information, or to determine whether or not you need to self-pay, please refer to your Group Insurance Handbook or call the Office of Group Insurance at 332-1860 or at "www.state.id.us/adm/insurance".

While on FMLA leave, PERSI benefits are "preserved." For example, if you have 57 months of service credit and take three months of unpaid leave for FMLA purposes, when you return to work, you will still have 57 months of service. Under the same scenario, if you take three months of paid leave for FMLA, when you return to work you will have 60 months of service.

5. Return to Work:

If you do not return to work following FMLA leave for reasons other than the continuation, recurrence, or onset of a serious health condition, or other circumstances beyond your control, you may be required to reimburse the Department for health insurance premiums paid on your behalf during your FMLA leave. Also, if you do not return from FMLA, you should contact the Office of Group Insurance for information regarding your rights for continuance of your life and medical insurance.

While you are on FMLA leave, the terms and conditions of employment pertaining to FMLA leave do not restrict or limit the Department's ability to engage in or impose actions as set forth in the Department's Personnel Policies. Upon your return from FMLA leave, you will be reinstated to the same or an equivalent job with the same pay, benefits, and terms and conditions of employment, unless your position has been affected by a layoff, or reorganization during the period of FMLA leave.

The Department may require that you provide a release to return to work if FMLA leave has been taken for your own serious health condition. You will will not be required to present a release to return to work prior to being restored to employment. If such certification is required but not received, your return to work may be delayed until such certification is provided.

You will will not be required to furnish us with reports of your status and intent to return to work every 30 days while on FMLA leave.

Any of the certification requirements outlined above may change while you are on FMLA leave. If that occurs, we will provide you with written notification of the change with as much advance notice as possible.

I have read and understood the above.

Employee's Signature

Date

Attachment: Physician Medical Certification Form (if applicable)

Distribution: 1 copy each to Supervisor, Employee, and Personnel file

Updated: 12/11/09

Family and Medical Leave

The information sought on this form relates only to the condition for which the employee is taking FMLA leave.

Medical Certification Statement for the **Employee's Own Serious Illness**

1. **Employee's Name:** _____
2. **Date condition began:** _____
3. **Probable duration of the condition or incapacity:** _____
4. **Medical facts regarding the condition (see attached definition of serious illness):**

5. **Explanation of extent to which employee is unable to perform the functions of his or her job:**

I certify that the "serious health condition" described above qualifies as an eligible FMLA condition as described in the attached definition:

Health Care Provider Signature:

Date: _____ Office Phone: _____

Type of Practice (Field of Specialization, if any): _____

Medical Release:

I authorize the release of any medical information necessary to process the above request. I understand that this medical information will be treated as confidential and will not be placed in my personnel file.

Signature of employee or authorized representative: _____

Date: _____